



Last Name:

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(512)-858-9355
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Welcome To Family First Chiropractic!

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, _____, have read the above, understand it.



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Last Name: _____

Date: _____ Social Security # _____

Name: _____
Last First M.I

Address _____ City _____ ST _____ Zip _____

E-mail (please provide for communication purposes) _____

Cell Phone: _____ Home Phone: _____

Sex: _____ Male _____ Female Age: _____ Birthdate: _____

____ Married ____ Separated ____ Widowed ____ Divorced ____ Single ____ Partnered for ____ Yrs ____ Minor

Preferred method of communication: (Check one) Email ____ Text ____ + Carrier Name _____ Phone _____

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SS# _____ - _____ - _____ Phone: _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes ____ No ____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home ____ Other ____

INSURANCE INFORMATION:

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Chae and Monya Tracy, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of above signature Relationship to Patient

Last Name: _____

Financial Responsibility

Patient Name _____

Dear Patient,

Family First Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you **MUST** bring the check into the office within 7 days so that we may properly credit your account.

I have read and understood all the above information.

Patient Signature

Date

X-Ray Consent

I hereby give my consent to Family First Chiropractic and its representatives to take x-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.

I have read and understood all the above information.

Patient Signature

Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*



familyfirst
CHIROPRACTIC

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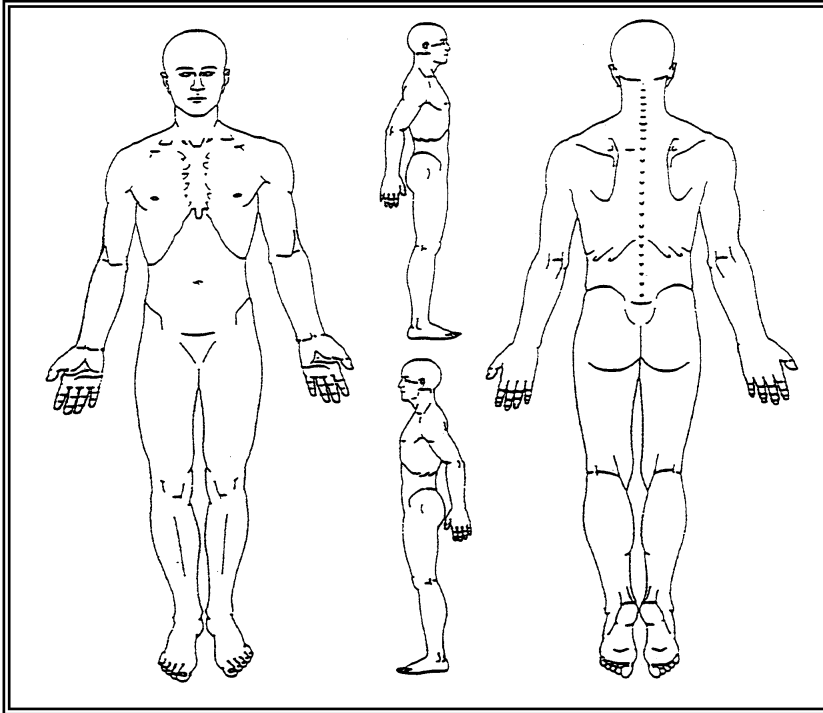
Last Name: _____

Please let us know who we can thank for referring you to our office: _____

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX // // // // // O O O O O O O O S S S S S - - - - -
 DULL/ACHY SHARP/STABBING NUMBNESS/TINGLING STIFF/TIGHT BURNING



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

- 0 = No Pain. No Discomfort
- 1 = Minimal Discomfort. Minor stiffness or tightness.
- 2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain. More than just sore. Uncomfortable.
- 4 = Mild Pain. Noticeable pain but tolerable.
- 5 = Moderate Pain. Aggravating. Still allows movement.
- 6 = Strong Pain. Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain. Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
- 9 = Severe Pain. Brings tears. Almost impossible to move.
- 10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Do you have any other health conditions, regardless of whether you think it's related to your spine:

Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____

How long have you been suffering with this problem, has it been more than a month or two? _____

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When was the first time you EVER recall having a problem in this area? _____

How often have you suffering with this problem? (Please indicate for each of the body area of concern)

Constant (75 – 100% of the time) _____ Frequent (50 – 75% of the time) _____
 Occasional (25 – 50% of the time) _____ Intermittent (0 – 25% of the time) _____

Every trauma is recorded in the spine. Please give a brief description of any significant injuries or accidents over the course of your life (slips, falls, injuries, car accidents) , whether or not you think they are related to your spine:

Did you go to the hospital for any of these injuries? _____

Did you get any X-rays for any of these injuries? _____

Did you get checked by a Chiropractor after any of these injuries? _____

List any MD's or Chiropractors you've already seen for your current problem:

What do you do most of the day in your job postures, positions and repetitive movements: _____

What tests have you already had for this problem? X-rays MRI C.T. Scan Myelogram EMG/NCV

None Other _____

What have you already tried for this problem? Anti-inflammatory Pain Meds Muscle Relaxers

Injections Physical Therapy Chiropractic Massage Exercise Other _____

What makes your problem worse? Sitting Standing Changing Position Walking Bending Lifting Twisting

Reaching Driving Sleeping Sneeze/Cough Computer Work Telephone Going From Sit to Stand

Other _____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

What area of your life has this problem affected the most? Family Relationships Work Exercise Recreation

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

Please list any concerns you may have about getting this problem corrected such as time or transportation:



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REVIEW OF SYMPTOMS

Please use the 0 to 4 guide below to rate each of the symptoms on this page according to your health status over the past 30 days.

- 1 - Occasionally have it, effect is not severe
- 2 - Occasionally have it, effect is severe
- 3 - Frequently have it, effect is not severe
- 4 - Frequently have it, effect is severe

HEAD ___ Headaches ___ Faintness ___ Dizziness ___ Insomnia Total _____	ENERGY/ACTIVITY ___ Fatigue, Sluggishness ___ Apathy, Lethargy ___ Hyperactivity ___ Restlessness Total _____	LUNGS ___ Chest Congestion ___ Asthma, Bronchitis ___ Shortness of Breath ___ Difficulty Breathing Total _____
EYES ___ Watery or Itchy Eyes ___ Swollen, Reddened or Sticky Eyelids ___ Bags or Dark Circles Under Eyes ___ Blurred or Tunnel Vision (does not include near or far-sighted) Total _____	WEIGHT ___ Binge Eating/Drinking ___ Craving Certain Foods ___ Excessive Weight ___ Compulsive Eating ___ Water Retention ___ Underweight Total _____	HEART ___ Irregular or Skipped Heartbeat ___ Rapid or Pounding Heartbeat ___ Chest Pain Total _____
EARS ___ Itchy Ears ___ Earaches, Ear Infections ___ Drainage from Ear ___ Ringing in Ears, Hearing Loss Total _____	EMOTIONS ___ Mood Swings ___ Anxiety, Fear, Nervousness ___ Anger, Irritability, Aggressiveness ___ Depression Total _____	DIGESTIVE TRACT ___ Nausea, Vomiting ___ Diarrhea ___ Constipation ___ Bloating Feeling ___ Belching, Passing Gas ___ Heartburn ___ Intestinal/Stomach Pain Total _____
NOSE ___ Stuffy Nose ___ Sinus Problems ___ Hay Fever ___ Sneezing Attacks ___ Excessive Mucus Formation Total _____	MIND ___ Poor Memory ___ Confusion, Poor Comprehension ___ Poor Concentration ___ Poor Physical Condition ___ Difficulty in Making Decisions ___ Stuttering or Stammering ___ Slurred Speech ___ Learning Disabilities Total _____	OTHER ___ Frequent Illness ___ Frequent or Urgent Urination ___ Genital Itch or Discharge Total _____
MOUTH/THROAT ___ Chronic Coughing ___ Gagging, Frequent Need to Clear Throat ___ Sore Throat, Hoarseness, Loss of Voice ___ Swollen or Discolored Tongue, Gums/Lips ___ Canker Sores Total _____	JOINTS/MUSCLE ___ Pain or Aches in Joints ___ Arthritis ___ Stiffness or Limited Movement ___ Pain or Aches in Muscles ___ Feeling of Weakness or Tiredness Total _____	GRAND TOTAL _____

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PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

Please list any surgeries you have had over the course of your life: _____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? Yes No If yes, please list: _____

List any medications you are taking: _____

FAMILY HISTORY

Mother: Living Deceased List any medical problems: _____

Father: Living Deceased List any medical problems: _____

List any problems common in your family: Cancer Diabetes Heart disease High blood pressure Stroke Arthritis
Scoliosis Thyroid disease Osteoporosis Other _____

SOCIAL HISTORY

Do you have any children? Yes No If yes, how many? _____

Do you drink alcohol? Yes No If yes, how much & how often? _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

PERSONAL HEALTH GOALS

<input type="checkbox"/> Improve Nutrition/Eating Habits	<input type="checkbox"/> Lower Cholesterol	<input type="checkbox"/> Get off Medications
<input type="checkbox"/> Weight Loss/Fat Loss	<input type="checkbox"/> Lower Blood Pressure	<input type="checkbox"/> Improved Sleep
<input type="checkbox"/> Increase Lean Muscle Mass	<input type="checkbox"/> Start Exercising	<input type="checkbox"/> Improved Energy
<input type="checkbox"/> Increase Bone Density	<input type="checkbox"/> Look Better	<input type="checkbox"/> Improved Posture
<input type="checkbox"/> Reduce Stress	<input type="checkbox"/> Feel Better	<input type="checkbox"/> Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

Who is your Family Physician or Primary Doctor that monitors you? _____

When was the last time you had blood work done? _____



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Please answer the questions on a scale of 1 to 10 , 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement... BE HONEST WITH YOURSELF.

Physical Health

- 1. I am a physically fit person and formally exercise on a regular basis.
1 2 3 4 5 6 7 8 9 10
- 2. I have a physically attractive body that I am proud to look at in the mirror.
1 2 3 4 5 6 7 8 9 10
- 3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
1 2 3 4 5 6 7 8 9 10
- 4. I get at least 7 hours of sleep, 7 days a week
1 2 3 4 5 6 7 8 9 10
- 5. I have gotten regular Chiropractic care within the past 5 years.
1 2 3 4 5 6 7 8 9 10

Total _____

Emotional/Mental Health

- 6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
1 2 3 4 5 6 7 8 9 10
- 7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.
1 2 3 4 5 6 7 8 9 10
- 8. Most of the time, I am truly happy and feel a sense of purpose in my life.
1 2 3 4 5 6 7 8 9 10
- 9. I have healthy relationships and a rich social network of friends and activities.
1 2 3 4 5 6 7 8 9 10
- 10. I am organized, have time for myself, and can prioritize the important tasks in my life.
1 2 3 4 5 6 7 8 9 10

Total _____

Chemical/Nutritional Health

- 11. I eat 4-6 small meals daily and properly combine my protein, carbohydrates and fats.
1 2 3 4 5 6 7 8 9 10
- 12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
1 2 3 4 5 6 7 8 9 10
- 13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
1 2 3 4 5 6 7 8 9 10
- 14. I do not smoke cigarettes.
1 2 3 4 5 6 7 8 9 10
- 15. I drink water as my primary beverage and consume at least 30 ounces per day.
1 2 3 4 5 6 7 8 9 10

Total _____

Total of all 3 (physical, emotional, chemical) sections _____